	FO	R OHF	USE		

LL1

2002 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 003	34975			II. CERTI	FICATION BY AUTHORIZED FA	ACILITY OFFICER		
	Facility Name: Our Lady of Angels Retire Address: 1201 Wyoming Avenue Number County: Will	60435 Zip Cod	e	I have examined the contents of the accompanying report to the State of Illinois, for the period from 7-1-2001 to 6-30-2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider)					
	Telephone Number: 815725-6631 IDPA ID Number: 36-2486076	Fax # 815 715-1451			is based	ible instructions. Declaration of pr d on all information of which prepa ntional misrepresentation or falsific cost report may be punishable by f	arer has any knowledge. cation of any information		
	Date of Initial License for Current Owners: Type of Ownership:	8-10-1962			Officer or Administrator	(Signed)(Type or Print Name) <u>Sister Yv</u>	9-16-2002 (Date) onne Weidner, OSF		
	X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust	PROPRIETARY Individual Partnership	GOVERNME State County	NTAL	of Provider	(Title) CEO/Administrator (Signed)			
	IRS Exemption Code 501(c)(3)	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	Other		Paid Preparer	(Print Name and Title) (Firm Name & Address)	(Date)		
	In the event there are further questions about Name: Cheryl Shaw, Business Manager	this report, please contact: Telephone Number: 815 725-60	631			(Telephone) () MAIL TO: OFFICE OF ILLINOIS DEPARTME 201 S. Grand Avenue Ea Springfield, IL 62763-00	ENT OF PUBLIC AID		

STATE OF ILLINOIS Page 2

Facility Name & ID Numl	oer Our Lady of A	angels Retirement I	Iome			# 0034975 Report Period Beginning: 7-1-2001 Ending: 6-30-2002
III. STATISTICA	AL DATA					D. How many bed-hold days during this year were paid by Public Aid?
A. Licensure/	certification level(s) of o	care; enter number	of beds/bed days,			9 (Do not include bed-hold days in Section B.)
(must agree	with license). Date of c	hange in licensed b	eds	100		
			_			E. List all services provided by your facility for non-patients.
1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
						none
Beds at				Licensed		
Beginning of	Licensure	e	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? yes
Report Period	Level of C	are	Report Period	Report Period		
						G. Do pages 3 & 4 include expenses for services or
1	Skilled (SNF))			1	investments not directly related to patient care?
2	Skilled Pediatric (SNF/PED)				2	YES NO X
3 50	Intermediate	· /	50	18,250	3	
4	Intermediate/				4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5 50	Sheltered Car		50	18,250	5	YES NO X
6	ICF/DD 16 or	r Less			6	I O - had had Pilon advatored Production and the harden
7 100	TOTALS		100	26.500	_	I. On what date did you start providing long term care at this location?
7 100	IUIALS		100	36,500	7	Date started <u>08/10/1962</u>
						I Was the facility numbered or lessed often January 1, 10709
R Census-For	r the entire report perio	nd				J. Was the facility purchased or leased after January 1, 1978? YES Date NO X
1	2	3	4	5		
Level of Care	=	-	d Primary Source of	-		K. Was the facility certified for Medicare during the reporting year?
Level of care	Public Aid	y zever or our cure un			=	YES NO X If YES, enter number
	Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8 SNF	Î	•			8	· · ·
9 SNF/PED					9	Medicare Intermediary
10 ICF	3,311	14,001		17,312	10	
11 ICF/DD					11	IV. ACCOUNTING BASIS
12 SC		14,658		14,658	12	MODIFIED
13 DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14 TOTALS	3,311	28,659		31,970	14	Is your fiscal year identical to your tax year? YES X NO
	ccupancy. (Column 5, lin line 7, column 4.)	ne 14 divided by to 87.59%	tal licensed -		Tax Year: 06/30/2001 Fiscal Year: 06/30/2001 * All facilities other than governmental must report on the accrual basis.	

STA			

Page 3 6-30-2002 Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 **Report Period Beginning:** 7-1-2001 **Ending:**

	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
			osts Per Genera	- 0		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	_		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	303,885	11,433	2,041	317,359		317,359		317,359			1
2	Food Purchase		150,765		150,765		150,765		150,765			2
	Housekeeping	102,877	20,339		123,216		123,216		123,216			3
4	Laundry	43,667	4,694		48,361		48,361		48,361			4
5	Heat and Other Utilities			96,161	96,161		96,161		96,161			5
6	Maintenance	152,484	42,000	1,325	195,809		195,809		195,809			6
7	Other (specify):* Life Saftey Code			753	753		753		753			7
8	TOTAL General Services	602,913	229,231	100,280	932,424		932,424		932,424			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	970,121	23,963	6,280	1,000,364		1,000,364		1,000,364			10
	Therapy											10a
11	Activities	80,025	2,157		82,182		82,182		82,182			11
12	Social Services	58,175	1,830		60,005		60,005		60,005			12
13	Nurse Aide Training											13
14	Program Transportation		1,502	1,887	3,389		3,389		3,389			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,108,321	29,452	8,167	1,145,940		1,145,940		1,145,940			16
	C. General Administration											
17	Administrative	180,546			180,546		180,546		180,546			17
18	Directors Fees											18
19	Professional Services			11,048	11,048		11,048		11,048			19
20	Dues, Fees, Subscriptions & Promotions			11,524	11,524		11,524		11,524			20
21	Clerical & General Office Expenses	75,723	11,105	13,339	100,167		100,167		100,167			21
22	Employee Benefits & Payroll Taxes			240,675	240,675		240,675		240,675			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,154	4,154		4,154		4,154			24
25	Other Admin. Staff Transportation				İ							25
26	Insurance-Prop.Liab.Malpractice			37,636	37,636		37,636		37,636			26
27	Other (specify):*											27
28	TOTAL General Administration	256,269	11,105	318,376	585,750	•	585,750	•	585,750			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,967,503	269,788	426,823	2,664,114		2,664,114		2,664,114			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Our Lady of Angels Retirement Home #0034975

Report Period Beginning:

7-1-2001 Ending:

Page 4 6-30-2002

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			125,946	125,946		125,946		125,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			125,946	125,946		125,946		125,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	9,338	5,910		15,248		15,248		15,248			41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	9,338	5,910	27,375	42,623		42,623		42,623	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,976,841	275,698	580,144	2,832,683		2,832,683		2,832,683			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Our Lady of Angels Retirement Home VI. ADJUSTMENT DETAIL

0034975

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2 3	1
			Refer- OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence ONLY	
1	Day Care	\$	\$	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
	Non-Working Officer's or Owner's Salary			12
13	Sales Tax			13
	Non-Care Related Interest			14
_	Non-Care Related Owner's Transactions			15
	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
	Entertainment			19
-	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
	Malpractice Insurance for Individuals			23
	Bad Debt			24
25	Fund Raising, Advertising and Promotional			25
	Income Taxes and Illinois Personal			
26	Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising Other-Attach Schedule			28 29
		•		
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(Se	ee instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

Our Lady of Angels Retirement Home

ID#_	0034975
Report Period Beginning:	7-1-2001
Ending:	6-30-2002

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36	-			36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49
47	1 Otal	1 0	l	77

Summary A Facility Name & ID Number Our Lady of Angels Retirement Home SUMMARY OF PAGES 5. 5A, 6. 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 # 0034975 Report Period Beginning: 7-1-2001 6-30-2002 **Ending:**

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D,	6E, 6F, 6G, 61	H AND 6I										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0		14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0		17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0		18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0		19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0		20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0		21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0		22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0		23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0		24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0		25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0		26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS Summary B Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 6-30-2002 7-1-2001 Ending:

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	61	(to Sch V, col	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST						·							
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

0034975

Report Period Beginning:

7-1-2001

Ending: 6-30-2002

VII. RELATED PARTIES

our Eady of rangels recurement frome

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Effici below the fiames of ALL of	wilers and rei	ateu organizai	ed organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.									
1		2					3					
OWNERS		RELATED NURSING HOMES					OTHER RELATED BUSINESS ENTITIES					
Name	Ownership %	Name		City		Name		City	Type of Business			
				1990								
				1990								
							·					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

_	-		for determining costs as specifical						
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership		Costs (7 minus 4)	
	*7			0		Ownership	or gamzation	Costs (7 mmus 4)	
1	V			3			5	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7 **Our Lady of Angels Retirement Home** 0034975 **Report Period Beginning:** 7-1-2001 6-30-2002 Facility Name & ID Number **Ending:**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work					
					Compensation	Week Devoted to this		Compensati		Schedule V.	
					Received	Facility and	% of Total	in Costs		Line &	
				Ownership	From Other	Work Week		Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS	Page 8

Facility Name & ID Number Our Lady of Angels Retirement Home	#	0034975	Report Period Beginning:	7-1-2001	Ending:	i-30-2002
VIII. ALLOCATION OF INDIRECT COSTS						
			Name of Related	Organization		
A. Are there any costs included in this report which were derived from allocations of centra	ıl offic	e	Street Address			
or parent organization costs? (See instructions.) YES NO	X		City / State / Zip C	Code		
			Phone Number		()	
B. Show the allocation of costs below. If necessary, please attach worksheets.			Fax Number		()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11 12
12										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		S	25

STATE OF	ILLIN	OIS			Page 9

Facility Name & ID Number	Our Lady of Angels Retirement Home	# 0034975	Report Period Beginning:	7-1-2001	Ending:	6-30-2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1 2 3 4 5 6 7 8 9

	1	2	_	3	4	5	6	7	8	9	10	
	Name of Lender	Relate YES		Purpose of Loan	Monthly Payment Required	Date of Note	Amo Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital					1		<u> </u>				
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*					_			_			
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ Line #	

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0034975 Report Period Beginning: 7-1-2001 Ending: 6-30-2002

Facility Name & ID Number Our Lady of Angels Retirement Home

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

D. Real Estate Taxes					
Real Estate Tax accrual used on 2001 report.	<i>Important</i> , please see the next worksheet, bill must accompany the cost report.	"RE_Tax". The real	estate tax statement and	5	1
1. Iteal Estate Tax decidal ased on 2001 report.					
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment cove	rs more than one year, de	tail below.)	s	2
3. Under or (over) accrual (line 2 minus line 1).				s	3
4. Real Estate Tax accrual used for 2002 report. (Deta	l and explain your calculation of this accrual on the lines	below.)		s	4
5. Direct costs of an appeal of tax assessments which h (Describe appeal cost below. Attach cop	s	5			
6. Subtract a refund of real estate taxes. You must offs classified as a real estate tax cost plus one-half of an TOTAL REFUND \$ For	\$	6			
7. Real Estate Tax expense reported on Schedule V, lir	e 33. This should be a combination of lines 3 thru 6.			s	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year: 199			FOR OHF USE ONLY		
199 199	·	13	FROM R. E. TAX STATEMENT FO	OR 2001 \$	13
200 200	·	14	PLUS APPEAL COST FROM LINE	E 5 \$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CA	LCULATION \$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Our Lady of Ange	ls Retirement Home		COUNTY	Will
FAC	ILITY IDPH LICI	ENSE NUMBER	0034975			
CON	TACT PERSON I	REGARDING THIS	REPORT			
TEL	EPHONE ()		FAX#: ()	
Α.		al Estate Tax Cost				
	Enter the tax indecost that applies home property w	ex number and real e to the operation of th thich is vacant, rented		mn D. Real esta or used for purp	te tax applicable to oses other than lon	nter only the portion of the any portion of the nursing g term care must not be
	(A)	(B)		(C)	(D)
1. 2. 3. 4. 5. 6. 7. 8. 9.			Property Descrip		Total Tax S S S S S S S S S	\$ \$
			7	TOTALS	\$	\$
B.		Cost Allocations				
	used for nursing		to more than one nursin	ng home, vacant NO	property, or proper	ly which is not directly
			nedule which shows the out			
С	Toy Bille					

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which

is normally paid during 2002.

Page 10A

CTA	TE	OF I	LINOIS	CI .

Page 11

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 7-1-2001 Ending: 6-30-2002 X. BUILDING AND GENERAL INFORMATION: 115,326 **B.** General Construction Type: Frame Steel & Brick **Number of Stories** 2 Square Feet: Exterior Class C Does the Operating Entity? (a) Own the Facility X (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) X (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost 2

3 TOTALS

0034975

Report Period Beginning:

7-1-2001 Ending:

Page 12 6-30-2002

Facility Name & ID Number Our Lady of Angels Retirement Home # 003XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-Including Fixed Equip	2	3	4	5	6	7	8	9	$\overline{}$
	•	FOR OHF USE ONLY	Year	Year	•	Current Book	Life	Straight Line	· ·	Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4			111411111		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**									
	Roof			1980	8,000		20			8,000	9
	Roof			1980	62,245		20			62,245	10
	Roof			1983	44,000	2,200	20	2,200		44,000	11
	Blacktop			1983	45,578		15			45,578	12
	Console Page			1984	7,047		15			7,047	13
	Fire Alarm S	ystem		1984	38,030	1,902	20	1,902		36,112	14
	Roof Repair			1984	33,780	1,689	20	1,689		32,091	15
16	Air Cond			1985	17,599	880	20	880		15,840	16
	Blacktop			1985	5,246		15			5,246	17
	Amplifier			1987	1,400					1,400	18
	Steamer			1987	4,188		10			4,188	19
20	Shrubs and to			1987	5,154		10			5,154	20
	washroom Re	enovation		1988	2,330		10			2,330	21
	Linen Carts			1990	2,573	172	15	172		2,236	22
	boiler and Fi	re eyes		1990	23,441	1,172	20	1,172		15,236	23
	Boiler			1991	35,462	1,773	20	1,773		21,276	24
	Security Syste Kitchenette R			1991 1991	10,600	530 409	20 20	530 409		6,360	25 26
				1991	8,185					4,908	26
	North parkin			1992	20,183 6,858	1,346 216	15	1,346 216		16,152 7,290	28
	Floor Keeper Air Cond uni			1992	11,202	210	8	210		11,202	28
	Garage	ı		1992	9,900	660	15	660		7,315	30
	Fence Compa	actor		1992	886	59	15	59		634	31
	Sidewalk on			1992	10,038	502	20	502		6,229	32
33	Sidewalk circ			1992	23,707	1,185	20	1,185		12,935	33
34	Air Cond	ac .		1993	5,878	588	10	588		5,880	34
35	An Cond			1773	3,070	300	10	300		3,000	35
36											36
30					l			l	I	1	30

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Our Lady of Angels Retirement Home XI. OWNERSHIP COSTS (continued)

0034975

Report Period Beginning:

7-1-2001 Ending:

Page 12A

6-30-2002

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Improvement Type** Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation 1,633 37 Doors 1993 32,652 1,633 20 16,870 37 38 Multi purpose room 1993 11,359 568 20 568 5,680 38 39 Blacktop Reseal 1993 10,845 10,845 39 1993 51,950 3,463 15 3,463 34,630 40 Cooling Tower 40 1993 11,306 942 12 942 9,420 41 Room Numbers 41 17,330 15 42 Call System 1993 1994 26,000 1,733 1,733 42 43 Master Clocks 282 20 282 2,256 43 44 Flourscent Lights 1994 7,619 380 20 2,850 44 380 52 15 52 45 45 Lotcjem wall and door 1994 1,549 570 46 Library wall and door 20 39 429 46 1994 1,574 39 47 Doors 1994 18,079 452 20 452 4,972 47 48 Air Cond 1995 4,000 400 319 10 400 319 3,000 48 49 Fire Act Door Closures 1995 1995 1995 6,379 20 2,392 49 50 Door Closures 2,300 115 20 115 863 50 51 Burners (boiler) 18,279 914 20 914 6,855 51 52 remodel Admissions Office 892 1995 2,371 119 20 119 52 53 gas Lines 1995 562 28 20 28 210 53 54 Relocate duane controls 1,460 20 73 547 54 1995 73 1995 1,455 20 73 547 55 55 Remodel Lobby 73 1995 56 Doors 35,236 1,762 20 1,762 13,215 56 57 Telephone System 1995 17,881 20 57 6,705 58 Doors 58 20 1996 6,207 310 310 2,015 59 boiler Room 1,559 20 59 1996 1,830 92 20 92 60 60 kitchenette remodel 50 61 laundry room Lighting 1996 975 20 50 275 61 3,360 167,206 1996 3,360 20 21,840 62 62 windows 1996 5,500 1,781 63 63 elevator sensing edges 274 20 274 64 64 65 65 66 66 67 67 68 69 70 TOTAL (lines 4 thru 69) 895,298 33,688 33,688 554,978 70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0034975 Report I

Report Period Beginning:

7-1-2001 Ending: 6-

Page 12B 6-30-2002

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Constructed Improvement Type** Cost Depreciation in Years Depreciation Adjustments Depreciation 1 Totals from Page 12A, Carried Forward 895,298 33,688 33,688 554,978 2 sinks 20,932 1,046 1,046 6,799 2 3 Chain link fence 1997 3,268 164 20 164 902 3 1997 27,000 1,350 20 1,350 7,425 4 4 Boiler Rm abatement 5 windows 1997 57,944 2,898 20 2,898 16,209 5 418 2,299 6 Kitchen ceiling 1997 8,354 418 20 6 7 Roof 20 15,490 1997 177,000 2.213 2,213 8 Compressor 1997 20 8 1,722 43 43 215 1997 120 20 120 600 9 **Kitchen renovation** 4,800 10 Sound system/pews 2,616 20 325 10 1997 65 65 11 refurbish pews 1997 2,772 69 20 69 345 11 12 Roof replacement 1997 61,645 1,541 20 1,541 7,705 12 13 Roof project fees 1997 11,114 277 171 20 1,385 13 14 reroofing 1997 6,849 20 171 14 1998 318 20 35 15 15 skylight replacement 16 roofing 5,352 133 665 1998 133 20 16 17 roof 23,994 1998 599 20 599 2,997 17 18 roof 5,332 20 18 1998 268 67 67 11,245 19 reroof lightwells 2000 750 15 750 2,250 19 2000 2,277 152 15 152 456 20 20 new garage doors 21 circular ceiling 20,792 1,386 15 1,386 4,158 21 1,061 22 garage heaters 2000 15,912 15 22 1,061 3,183 23 24 25 23 24 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 1,366,536 48,218 48,218 629,544 34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0034975

Report Period Beginning:

7-1-2001 Ending:

Page 12C 6-30-2002

Facility Name & ID Number Our Lady of Angels Retirement Home # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See Instr	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		s 1,366,536	\$ 48,218		\$ 48,218	\$	\$ 629,544	1
2 pipe heating to main floor	2000	575	38	15	38		114	2
3 side altar	2000	5,400	360	15	360		1,080	3
4 2 lobby restrooms remodel ADA	2000	16,450	1,097	15	1,097		3,291	4
5 Remodel public restrooms ADA	2001	383	5	40	5		10	5
6 Remodel public restrooms ADA	2001	5,148	64	40	64		129	6
7 Remodel public restrooms ADA	2001	23,452	244	40	244		617	7
8 Bathroom remodel	2002	8,440	422	20	422		422	8
9 Bathroom remodel	2002	8,150	408	20	408		408	9
10 Bathroom remodel	2002 2002	8,150	408	20 20	408 422		408	10 11
11 Bathroom remodel	2002	8,438 7,822	422 391	20	391		422 391	11
12 Bathroom remodel 13	2002	7,022	391	20	391		391	13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28 29								28 29
30								30
31						ļ		31
32								32
33				-		 		33
34 TOTAL (lines 1 thru 33)		\$ 1,458,943	\$ 52,076		\$ 52,076	S	\$ 636,835	34
34 TOTAL (mics i miu 33)		3 1,430,743	3 32,070		32,070	9	9 030,633	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	OF	HI	INOIS	١

Page 13 Facility Name & ID Number **Our Lady of Angels Retirement Home** 0034975 **Report Period Beginning:** 7-1-2001 6-30-2002 **Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment De	preciation-Excluding	Transportation.	(See instructions.)

	Category of	ı î	C	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	D	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 416,818	\$	50,218	\$ 50,218	\$		\$ 122,146	71
72	Current Year Purchases	128,432		11,858	11,858			11,858	72
73	Fully Depreciated Assets								73
74									74
75	TOTALS	\$ 545,250	\$	62,076	\$ 62,076	\$		\$ 134,004	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	Patient Care	Ford Taurus Wgn 1997	1997	\$ 18,186	\$ 5,475	\$ 5,475	\$	5	\$ 18,186	76
77	Patient Care	Freedom Drivng Van 1999	1999	35,909	2,728	2,728		10	24,363	77
78	Patient Care	14 Pass Bus 2002	2002	54,750	3,591	3,591		10	5,475	78
79										79
80	TOTALS			\$ 108,845	\$ 11,794	\$ 11,794	\$		\$ 48,024	80

E. Summary of Care-Related Assets

		2

		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,113,038	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,946	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,946	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84	.]
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 818,863	85	

1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Curre	nt Book	Acc	umulated	
	Description & Year Acquired	Cost	Depre	ciation 3	Dep	reciation 4	
86	John Deer Tractor 1999	\$ 11,000	\$	1,100	\$	4,400	86
87	Chev Pickup 1998	26,820		5,364		24,138	87
88	Buick Century 2001	19,932		3,986		4,983	88
89							89
90							90
91	TOTALS	\$ 57,752	\$	10,450	\$	33,521	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Fac	ility Name & II	D Number	Our Lady of Angels	Retirement	Home	STA #	ATE OF ILLINOIS 0034975	R	eport Period I	Beginning:	7-1-2001	Ending:	Page 14 6-30-2002
XII	 Name of I Does the f 	nd Fixed Equi Party Holding			al amount shown below on	line	7, column 4? YES N	10					
		1 Year Constructe	2 Number	3 Date of Lease	4 Rental Amount		5 Total Years of Lease	6 Total Yes Renewal Or					
3	Original Building: Additions	1962	100	07/00	\$ 0				3		ive dates of current ing 07/01/2000 07/01/2009	rental agreei	ment:
5	Additions								5	Enumg	07/01/2009	_	
7	TOTAL		100		s	_			7		o be paid in future agreement:	years under t	he current
	This amo		ortization of lease expense ated by dividing the total se							Fiscal Y 12	Zear Ending 2002/2003 2003/2004	Annual Ros	ent
	9. Option to	Buy:	YES X	NO	Terms:		*			14.	2004/2005	\$	
	15. Îs Moval	ble equipment	ransportation and Fixed rental included in buildin wable equipment:		(See instructions.) Description:		YES X N (Attach a schedule		breakdown of	`movable equip	oment)		
	C. Vehicle Re	ental (See instr											
	1 Use		2 Model Year and Make		3 Monthly Lease Payment		4 Rental Expense for this Period			* If the	ere is an option to l	ouv the buildi	nσ
17 18	380		anu man	\$	1 ajment	\$	101 tili5 i ti 10U	17 18			se provide complete		
19 20								19 20		** TL:~	amount plus any a	moutizatio	flooro
	TOTAL			\$		\$		21			nse must agree wit		

Facility Name & ID Number	Our Lady of Angels Retirement Home		#	0034975	Report Perio	d Beginning:	7-1-2001	Ending:	6-30-2002
XIII. EXPENSES RELATING TO NUI	RSE AIDE TRAINING PROGRAMS (See	instructions.)		-					
A. TYPE OF TRAINING PROGR	RAM (If aides are trained in another facili	y program, attach a schedule listing th	e facility	name, addres	s and cost per	aide trained in th	at facility.)		
1. HAVE YOU TRAINED A		2. CLASSROOM PORTION:			3.	CLINICAL PO	RTION:	_	
DURING THIS REPORT PERIOD?	X NO	IN-HOUSE PROGRAM				IN-HOUSE PRO	OGRAM		
If "yes", please complete	the nemainder	IN OTHER FACILITY				IN OTHER FAC	CILITY		
of this schedule. If "no", explanation as to why this	provide an	COMMUNITY COLLEGE				HOURS PER A	IDE		
not necessary.	stianing was	HOURS PER AIDE							

B. EXPENSES

ALLOCATION OF COSTS (d)

1 2 3 4

		Fa	cility		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
	Transportation				
	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

Page 15

\$	

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 7-1-2001 Ending: 6-30-2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(1	2	3	4	5	6	7	8	
		Schedule V	Stafi	i	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

(last day of reporting year)

As of 6-30-2002

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached.

		1		2 After	
		О	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	505,583	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		74,762		3
4	Supply Inventory (priced at)		7,466		4
5	Short-Term Investments				5
6	Prepaid Insurance		3,365		6
7	Other Prepaid Expenses		1,981		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	593,157	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost				14
15	Leasehold Improvements, at Historical Cost		2,113,038		15
16	Equipment, at Historical Cost		(1,913,380)		16
17	Accumulated Depreciation (book methods)				17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	199,658	\$	24
					
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	792,815	\$	25

		1 Op	erating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	16,970	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		80,488		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Payroll Deduction		72		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	97,530	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	97,530	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	695,285	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	792,815	\$	48

^{*(}See instructions.)

Ending:

6-30-2002

<u>JF CF</u>	IANGES IN EQUITY			
			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	576,875	1
2	Restatements (describe):		ĺ	2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	576,875	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		118,410	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	118,410	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21	· ·		<u> </u>	21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	695,285	24
23	,		695,285	+

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1	

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 2,863,907	1
2	Discounts and Allowances for all Levels	(122,618)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,741,289	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	29,956	12
13	Barber and Beauty Care	2,477	13
14	Non-Patient Meals	520	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,878	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,467	21
22	Laundry	1,105	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,403	23
	D. Non-Operating Revenue		
24	Contributions	110,651	24
25	Interest and Other Investment Income***	38,893	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149,544	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	2,857	27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,857	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,951,093	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		932,424	31
32	Health Care		1,145,940	32
33	General Administration		585,750	33
	B. Capital Expense			
34	Ownership		125,946	34
	C. Ancillary Expense			
35	Special Cost Centers		15,248	35
36	Provider Participation Fee		27,375	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	2,832,683	40
	TOTTLE BITT BE (SUM OF MICO OF MICO)	_	2,002,000	1
41	Income before Income Taxes (line 30 minus line 40)**		118,410	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	118,410	43

This mus	t agree with	page 4,	line 45, 0	column 4.
----------	--------------	---------	------------	-----------

^{*} Does this agree with taxable income (loss) per Federal Income
Tax Return? n/a If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Our Lady of Angels Retirement Home

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This	schedule	e must	cover t	he ent	ire repor	ting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	2,295	2,461	\$ 55,436	\$ 22.53	1
2	Assistant Director of Nursing	1,859	2,000	43,351	21.68	2
	Registered Nurses	14,754	17,930	226,041	12.61	3
4	Licensed Practical Nurses	13,472	15,148	233,363	15.41	4
5	Nurse Aides & Orderlies	31,239	34,419	387,040	11.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	912	1,040	15,314	14.73	9
10	Activity Assistants	6,069	6,820	60,981	8.94	10
11	Social Service Workers	3,831	4,175	58,175	13.93	11
12	Dietician					12
13	Food Service Supervisor	1,976	1,808	34,177	18.90	13
14	Head Cook	5,732	6,293	60,513	9.62	14
15	Cook Helpers/Assistants	22,185	23,795	174,293	7.32	15
16	Dishwashers	5,062	5,241	34,901	6.66	16
17	Maintenance Workers	9,116	10,361	152,484	14.72	17
18	Housekeepers	12,987	14,240	102,877	7.22	18
19	Laundry	4,856	5,461	43,668	8.00	19
20	Administrator	1,642	1,872	57,398	30.66	20
21	Assistant Administrator					21
22	Other Administrative	7,437	8,320	123,148	14.80	22
23	Office Manager					23
24	Clerical	7,156	7,823	75,724	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca UA assistants	3,682	3,895	24,889	6.39	32
33	Other(specify) Snk Bar&gift shop	1,330	1,424	9,338	6.56	33
34	TOTAL (lines 1 - 33)	157,592	174,526	\$ 1,973,111 *	\$ 11.31	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		s 2,041	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		5,000	10-3	38
39	Pharmacist Consultant		1,280	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 8,321		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53
	•		•	•	

^{**} See instructions.

0034975

Facility Name & ID Number

Envir Recyc

Gall & Speck

City of Joliet

Zizzo

Our Lady of Angels Retirement Home

Recycling

Acc Cont

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

Maint Contr

Maint Contr

XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Name Function Description Amount Amount Amount **IDPH License Fee** Sr. Yvonne Weidner, OSF Administrator 57,398 Workers' Compensation Insurance 18,332 27,375 Cheryl Shaw 43,433 **Unemployment Compensation Insurance** 302 Advertising: Employee Recruitment 2,616 0 Bus. Mgr 26,643 117,824 Health Care Worker Background Check Sr. Elaine Murphy Admission 0 FICA Taxes Craig Tuntland PR/Dev 0 19,428 **Employee Health Insurance** 69,449 (Indicate # of checks performed Rita Blankenship 33,645 Employee Meals Books & Subs 4.081 Hum Res Illinois Municipal Retirement Fund (IMRF)* Memberships 4,252 Pension Plan 33,000 Licenses 575 TOTAL (agree to Schedule V, line 17, col. 1) employee emply physcials 1,768 DPH license fee is shown on pg 4, line42 (27,375) (List each licensed administrator separately.) subtract out to equa; schV ln 20 col8 180,547 B. Administrative - Other Less: Public Relations Expense Description Non-allowable advertising Amount Yellow page advertising TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, 240,675 11,524 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar** (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Pavee Description Line# Type Amount Amount Geo Bagley & Co Accounting 3,401 Out-of-State Travel McCarthy&McHugh Accounting **500** Tracy, Johnson 19 Legal 250 Ill sec of State Legal In-State Travel 50 Gallagher Captive Ser Legal

TOTAL

3,711

2,882

130

105

11,048

Seminar Expense

ee attached schedule detail

Entertainment Expense

(agree to Sch. V,

line 24, col. 8)

Page 21

6-30-2002

4,154

4,154

Ending:

7-1-2001

Report Period Beginning:

^{*} Attach copy of IMRF notifications

TOTAL

**See instructions.

Report Period Beginning: 7-1-2001 Ending: 6-30-2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		\$	\$	\$	\$	\$	s	s	s	s

Facility	S y Name & ID Number Our Lady of Angels Retirement Home	STATE OF I #	ILLINOIS 0034975	Report Period Beginning:	7-1-2001	Ending:	Page 23 6-30-2002
XX. G	ENERAL INFORMATION:			•			
	Are nursing employees (RN,LPN,NA) represented by a union?	(13) Hay	ive costs for all su Department of I	applies and services which are of the Public Aid, in addition to the daily r	e type that can late, been proper	be billed to	
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	in t	the Ancillary Sec	tion of Schedule V? yes	_		_
(3)	Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?	the is a	e patient census li a portion of the b	uilding used for any function other sted on page 2, Section B? yes uilding used for rental, a pharmacy, splains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?	on	licate the cost of Schedule V. ated costs?		ssified to employ meal income be the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 15yrs		avel and Transpo	rtation cluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,228 Line 10,col 2	I b. I	If YES, attach a	complete explanation. parate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	c. V	program during to What percent of a	his reporting period. \$ ill travel expense relates to transport ge logs been maintained? yes	0		
(8)	Are you presently operating under a sale and leaseback arrangement? no	e. <i>A</i>	Are all vehicles s times when not in	tored at the nursing home during the use? yes			
(9)	Are you presently operating under a sublease agreement? YESx NO	C	out of the cost re	ommuting or other personal use of oort? yes y transport residents to and fr			***
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.]	Indicate the ar	nount of income earned from p during this reporting period.	oriding such \$ \$	h	<u>no</u>
		Fin	m Name:	erformed by an independent certific	•	The instruct	no tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 27,375 This amount is to be recorded on line 42 of Schedule V.		st report require t en attached?	hat a copy of this audit be included If no, please explain.	with the cost re	port. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.		we all costs which t of Schedule V?	h do not relate to the provision of lo	ong term care be	en adjusted o	out
		per	rformed been atta	e in excess of \$2500, have legal inviced to this cost report? a summary of services for all archives.		-	ices